

## Complete Summary

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### GUIDELINE TITLE

Depression and mania in patients with HIV/AIDS. Mental health care for people with HIV infection.

### BIBLIOGRAPHIC SOURCE(S)

Depression and mania in patients with HIV/AIDS (updated online 2005 Mar). In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 1-20.

### GUIDELINE STATUS

This is the current release of the guideline.

## COMPLETE SUMMARY CONTENT

SCOPE  
 METHODOLOGY - including Rating Scheme and Cost Analysis  
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## SCOPE

### DISEASE/CONDITION(S)

- Human immunodeficiency virus (HIV) infection
- Mental disorders in HIV-infected patients:
  - Depression
  - Mania

### GUIDELINE CATEGORY

Diagnosis  
 Evaluation  
 Management

Screening  
Treatment

#### CLINICAL SPECIALTY

Allergy and Immunology  
Family Practice  
Infectious Diseases  
Internal Medicine  
Psychiatry

#### INTENDED USERS

Advanced Practice Nurses  
Health Care Providers  
Physician Assistants  
Physicians  
Public Health Departments

#### GUIDELINE OBJECTIVE(S)

To provide guidelines for diagnosis and treatment of depression and mania in patients with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) in primary care settings

#### TARGET POPULATION

Patients with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)

#### INTERVENTIONS AND PRACTICES CONSIDERED

Depression (Screening, Diagnosis, Treatment)

1. Screening for depression using one of the screening tool options
2. Use of Diagnostic and Statistical Manual of Mental Disorders - IV (DSM-IV) criteria
3. Paying specific attention to patients taking interferon-alpha and those with changes in body fat
4. Antidepressant medications:
  - Selective serotonin reuptake inhibitors
  - Novel antidepressants
  - Tricyclic antidepressants
  - Psychostimulants
5. Psychotherapy
6. Alternative therapies (e.g., St. John's Wort)
7. Follow-up

Mania (Screening, Diagnosis, Treatment)

1. Use of DSM-IV diagnostic criteria for mania

2. Prompt referral of patients experiencing mania for psychiatric consultation
3. Medications
4. Combination of psychotherapy with medication

#### MAJOR OUTCOMES CONSIDERED

- Effectiveness of screening techniques in detecting unrecognized depression
- Effectiveness of interventions to treat depression

### METHODOLOGY

#### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

#### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

#### NUMBER OF SOURCE DOCUMENTS

Not stated

#### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

#### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

#### METHODS USED TO ANALYZE THE EVIDENCE

Review

#### DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

#### METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

#### DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Human Immunodeficiency Virus (HIV) Guidelines Program works directly with committees composed of HIV Specialists to develop clinical practice guidelines. These specialists represent different disciplines associated with HIV care, including infectious diseases, family medicine, obstetrics and gynecology, among others. Generally, committees meet in person 3 to 4 times per year, and otherwise conduct business through monthly conference calls.

Committees meet to determine priorities of content, review literature, and weigh evidence for a given topic. These discussions are followed by careful deliberation to craft recommendations that can guide HIV primary care practitioners in the delivery of HIV care. Decision making occurs by consensus. When sufficient evidence is unavailable to support a specific recommendation that addresses an important component of HIV care, the group relies on their collective best practice experience to develop the final statement. The text is then drafted by one member, reviewed and modified by the committee, edited by medical writers, and then submitted for peer review.

#### RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

#### COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

#### METHOD OF GUIDELINE VALIDATION

Peer Review

#### DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

### RECOMMENDATIONS

#### MAJOR RECOMMENDATIONS

##### Depression

##### Screening for Depression

Clinicians should screen for depression as part of the annual mental health assessment and whenever symptoms suggest its presence.

See the original guideline document for screening techniques, symptoms of depression, and behavioral changes that may be indications of an underlying depressive disorder.

HIV-infected patients do not become depressed simply because their disease progresses; however, it is particularly important to screen for depression during the crisis points noted below.

#### Crisis Points for HIV-Infected Persons

- Learning of HIV-positive status
- Disclosure of HIV status to family and friends
- Introduction of medication
- Occurrence of any physical illness
- Recognition of new symptoms/progression of disease (e.g., major decrease in CD4 cells, increase in viral load)
- Necessity of hospitalization (particularly the first hospitalization)
- Death of a significant other
- Diagnosis of AIDS
- A return to a higher level of functioning (e.g., re-entry into job market/school, giving up entitlements)
- Major life changes (e.g., childbirth, pregnancy, loss of job, end of relationship, relocation)
- Necessity of making end-of-life and permanency planning decisions

#### Diagnosis

Clinicians should use the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) to diagnose depression (see table below).

Diagnostic Criteria For Major Depressive Episodes
<p>A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.</p> <p>Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.</p> <ol style="list-style-type: none"> <li>1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, this can be irritable mood.</li> <li>2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)</li> <li>3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.</li> <li>4. Insomnia or hypersomnia nearly every day</li> <li>5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)</li> <li>6. Fatigue or loss of energy nearly every day</li> </ol>

Diagonostic Criteria For Major Depressive Epsiodes
<ol style="list-style-type: none"> <li>7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)</li> <li>8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)</li> <li>9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide</li> </ol> <p>B. The symptoms do not meet criteria for a mixed episode.</p> <p>C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.</p> <p>D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).</p> <p>E. The symptoms are not better accounted for by bereavement (i.e., after the loss of a loved one), the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.</p>

### Depression and Co-Existing Medical Conditions

The primary care clinician should work closely with a psychiatrist throughout the course of treatment if depressive symptoms are associated with medication, and the benefit of continuing the medication outweighs the risk. In these situations, antidepressant therapy should be considered.

#### Key Point

Patients co-infected with hepatitis C virus (HCV), patients receiving treatment with interferon, and patients with disfiguring side effects of highly active antiretroviral therapy (HAART), particularly body fat changes, are more prone to develop depressive symptoms.

### Depression in Patients with Human Immunodeficiency Virus (HIV)/Hepatitis C Co-Infection

Clinicians who prescribe interferon-alpha should screen patients for depression at least every 4 weeks while they are receiving treatment (Hauser et al., 2002).

Clinicians who prescribe interferon-alpha should consult with a psychiatrist when treating patients with a history of psychiatric disorders, including depression and substance use.

#### Key Point

There is a growing amount of evidence that a history of psychiatric disorders, such as depression, does not necessarily increase the risk of developing depression while receiving interferon.

#### Depression in Patients Experiencing Body Fat Changes

Clinicians should assess mood at every visit in patients who develop changes in body fat.

#### Key Point

Patients report that clinicians minimize the importance of body fat changes.

#### Management of HIV-infected Patients with Depression

Clinicians should implement interventions, such as medications or psychotherapy, for patients with moderate to severe depression or mild depression that does not resolve in 2 to 4 weeks.

#### Referral

Patients at high risk for suicide or other violent behavior should be referred for immediate psychiatric intervention (see the National Guideline Clearinghouse (NGC) summary of the New York State Department of Health guideline [Suicidality in Patients With HIV/AIDS](#)).

#### Antidepressant Medications

Clinicians should individualize therapy, considering drug-drug interactions with HIV-related medications, presence of comorbid psychiatric disorder(s), presenting symptoms, and side effect profile.

#### Key Point

As in other vulnerable populations, the concept "start low, go slow" remains the cornerstone of psychiatric medication prescribing for HIV-infected patients.

Refer to Table 6-3 in the original guideline document for a list of commonly used antidepressants.

Refer to Appendix I in the "Companion Documents" field for dosing information, side effect profile, and drug-drug interactions.

#### Selective Serotonin Reuptake Inhibitors (SSRI) and Novel Antidepressant Medications

Clinicians should ask patients who are receiving SSRIs about sexual side effects.

Clinicians should monitor patients for suicidal ideation during the initiation phase of SSRI treatment. Clinicians should consider discontinuing medication in patients

whose depression is persistently worse or whose emergent suicidality is severe, abrupt in onset, or was not part of the presenting symptoms.

### Tricyclic Antidepressants

Clinicians should monitor serum drug levels to ensure appropriate dosing of tricyclic antidepressants when there are concerns about adherence, absorption, or drug interactions.

### Psychotherapy

Clinicians should refer patients for psychotherapy in the following situations:

- When basic supportive psychoeducational interventions are deemed ineffective in alleviating mood symptoms
- When patients with depressive symptoms refuse (or prefer not to take) recommended psychotropic medication
- When situational events precipitate mild to moderate depressive symptoms
- When patients appear to have difficulty accepting the diagnosis of a mood disorder (especially when this appears to cause high-risk behavior or non-adherence to medication)
- When patients request a referral

### Key Point

Combining psychotherapy with antidepressant and mood-stabilizing medications is the most effective treatment option for many patients. If treatment with medications is not possible (e.g., some patients in recovery are opposed to taking psychotropic medications), psychotherapy alone may be as effective as medication in cases of mild to moderate depression.

### Alternative Therapies for Depression

Clinicians should inform patients who decide to use alternative treatments of the following:

- Drug interactions and toxicities may occur.
- These treatments may take longer to be effective.
- These medications are not well studied.

Clinicians should inform patients that concomitant use of St. John's Wort with protease inhibitors (PIs) or non-nucleoside reverse transcriptase inhibitors (NNRTIs) is contraindicated because it may lead to subtherapeutic antiretroviral (ARV) drug concentrations.

### Treatment Follow-Up

After initiating treatment, clinicians should schedule a brief visit or phone conversation every 1 to 2 weeks to support adherence, assess response and side effects, and remind the patient that it may take 3 weeks or longer for mood to

improve. After 3 to 4 weeks, the clinician should perform an in-person assessment of symptom improvement.

During the maintenance phase of treatment with antidepressant medication, clinicians should schedule a brief visit every 4 to 12 weeks to assess adherence, sustained therapeutic response, and side effects.

After referring patients to another provider for medication or psychotherapy, primary care clinicians should schedule a brief visit or phone conversation within 1 to 4 weeks after the referral to ensure that the patient followed through (Simon et al., 2004).

Clinicians should encourage patients who experience recurrent depression to remain on medication indefinitely.

Primary care clinicians should maintain ongoing coordination of care with the patient's mental health care provider.

### Mania

Clinicians should immediately refer patients experiencing mania for psychiatric evaluation and care.

### Diagnosis

Clinicians should consult with or refer patients to a psychiatrist when there is doubt concerning the diagnosis.

Clinicians should consult with or refer patients to a psychiatrist when it is not clear whether patients are hypomanic or depressed.

Clinicians should use the DSM-IV diagnostic criteria for mania (see table below).

Diagnostic Criteria for Manic Episode
<p>A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).</p> <p>B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:</p> <ol style="list-style-type: none"><li>1. Inflated self-esteem or grandiosity</li><li>2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)</li><li>3. More talkative than usual or pressure to keep talking</li><li>4. Insomnia or hypersomnia nearly every day</li><li>5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)</li><li>6. Flight of ideas or subjective experience that thoughts are racing</li><li>7. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)</li></ol>

#### Diagnostic Criteria for Manic Episode

8. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  9. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- C. The symptoms do not meet criteria for a Mixed Episode.
- D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

#### Diagnostic Criteria for Mixed Episode

- A. The criteria are met both for a Manic Episode and for a Major Depressive Episode (except for duration) nearly every day during at least a 1-week period.
- B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

#### Diagnostic Criteria for Hypomanic Episode

- A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
1. Inflated self-esteem or grandiosity
  2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
  3. More talkative than usual or pressure to keep talking
  4. Flight of ideas or subjective experience that thoughts are racing
  5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
  6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
  7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

Diagnostic Criteria for Manic Episode
<p>C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.</p> <p>D. The disturbance in mood and the change in functioning are observable by others.</p> <p>E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.</p> <p>F. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).</p>
<p>Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.</p>

## Management of HIV-Infected Patients with Mania

Until patients with mania are stabilized, clinicians should maintain consultation with a psychiatrist or the patient should be under psychiatric care.

### Medications

#### Key Point

Treating hypomanic patients with antidepressants may lead to a full-blown episode of mania.

Refer to Table 6-5 in the original guideline document for commonly used medications to treat mania.

### CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

- Appropriate screening, diagnosis, and treatment of depression and mania in patients with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Simple screening techniques tested in a general primary care setting have been shown to be effective in detecting unrecognized depression.
- Mild depression may resolve within 2 to 4 weeks with support and education alone. For some patients, medication alone may be sufficient to ease their depression; for others, the combination of medication and psychotherapy will provide a more effective and perhaps faster response.

## POTENTIAL HARMS

Refer to Appendix I in the "Companion Document" field for side effect profile and drug-drug interactions.

## CONTRAINDICATIONS

### CONTRAINDICATIONS

Refer to Appendix I in the "Companion Document" field for contraindications between human immunodeficiency virus (HIV)-related medications and psychotropic medications.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

Following the development and dissemination of guidelines, the next crucial steps are adoption and implementation. Once practitioners become familiar with the content of guidelines, they can then consider how to change the ways in which they take care of their patients. This may involve changing systems that are part of the office or clinic in which they practice. Changes may be implemented rapidly, especially when clear outcomes have been demonstrated to result from the new practice such as prescribing new medication regimens. In other cases, such as diagnostic screening, or oral health delivery, however, barriers emerge which prevent effective implementation. Strategies to promote implementation, such as through quality of care monitoring or dissemination of best practices, are listed and illustrated in the companion document to the original guideline (HIV clinical practice guidelines, New York State Department of Health; 2003), which portrays New York's HIV Guidelines Program. The general implementation strategy is outlined below.

- Statement of purpose and goal to encourage adoption and implementation of guidelines into clinical practice by target audience.
- Define target audience (providers, consumers, support service providers).
  - Are there groups within this audience that need to be identified and approached with different strategies (e.g., HIV Specialists, family practitioners, minority providers, professional groups, rural-based providers)?
- Define implementation methods.

- What are the best methods to reach these specific groups (e.g., performance measurement consumer materials, media, conferences)?
- Determine appropriate implementation processes.
  - What steps need to be taken to make these activities happen?
  - What necessary processes are internal to the organization (e.g., coordination with colleagues, monitoring of activities)?
  - What necessary processes are external to the organization (e.g., meetings with external groups, conferences)?
  - Are there opinion leaders that can be identified from the target audience that can champion the topic and influence opinion?
- Monitor progress.
  - What is the flow of activities associated with the implementation process and which can be tracked to monitor the process?
- Evaluate.
  - Did the processes and strategies work? Were the guidelines implemented?
  - What could be improved in future endeavors?

## IMPLEMENTATION TOOLS

### Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better  
Living with Illness

### IOM DOMAIN

Effectiveness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Depression and mania in patients with HIV/AIDS (updated online 2005 Mar). In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 1-20.

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Feb

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

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Mental Health Guidelines Committee

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#### FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

#### GUIDELINE STATUS

This is the current release of the guideline.

#### GUIDELINE AVAILABILITY

Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

#### AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- HIV clinical practice guidelines. New York (NY): New York State Department of Health; 2003. 36 p. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix I: interactions between HIV-related medications and psychotropic medications: indications and contraindications. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix II: HIV-related causes of psychiatric symptoms: differential diagnosis. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix III: rating scales. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix IV: mental health care resources in New York State. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

- Appendix V: syringe access resources in New York State. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).
- Appendix VI: permanency planning and transitional services. New York (NY): New York State Department of Health; 2001 Mar. Electronic copies: Available from the [New York State Department of Health AIDS Institute Web site](#).

Print copies: Available from Office of the Medical Director, AIDS Institute, New York State Department of Health, 5 Penn Plaza, New York, NY 10001; Telephone: (212) 268-6108

## PATIENT RESOURCES

None available

## NGC STATUS

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Date Modified: 9/25/2006